BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

JORGE H. PLEITEZ	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,060,637
RV PRODUCTS, INC.	)	
Respondent	)	
AND	)	
	)	
TRAVELERS PROPERTY CASUALTY CO. OF AMERICA	)	
Insurance Carrier	)	

ORDER

Respondent requested review of the June 18, 2014, Award by Administrative Law Judge (ALJ) John D. Clark.[1] The Board heard oral argument on October 22, 2014, in Wichita, Kansas.

APPEARANCES

James B. Zongker, of Wichita, Kansas, appeared for the claimant. William L. Townsley, III, of Wichita, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ found claimant was injured out of and in the course of his employment with respondent each and every working day from January 3, 2012, through April 9, 2012. The ALJ awarded claimant a 24 percent whole person impairment as a result of his work

[1] Due to the retirement of ALJ Clark, this appeal has been transferred to ALJ Gary K. Jones.

injuries. He further found claimant had not unreasonably refused medical treatment as "the only suggested medical treatment was a repeat EMG for the bilateral carpal tunnel syndrome and left shoulder strengthening exercises."[2] The ALJ found claimant entitled to outstanding medical, unauthorized medical up to the statutory limit, and future medical based upon the opinions of Dr. Prostic that claimant will more than likely need additional treatment to his shoulders and hands, to be provided upon proper application.

Respondent appeals arguing the ALJ erred in relying upon the opinions of physicians who were provided false information, and in discounting the clear and unrefuted evidence that claimant's work history was extensive regarding manual intensive labor and that his right shoulder injury was well-documented several years before his alleged accident. Respondent argues claimant's demand for permanent partial disability benefits should be denied as claimant's work activities are not the prevailing factor for the conditions diagnosed, and because claimant refused additional medical care without explanation. Should the Board find the claim compensable, respondent contends claimant should only be entitled to a 2 percent right upper extremity impairment.

Claimant contends the Award should be affirmed in all respects.

The issues on appeal are:

1. Did claimant sustain an accidental injury arising out of and in the course of his employment with respondent?

2. What is the nature and extent of claimant's injuries, if any?

3. Has claimant unreasonably refused medical treatment?

4. Is claimant entitled to future medical treatment?

FINDINGS OF FACT

Claimant's job with respondent was as an assembler. Claimant worked for respondent for nine years. The job required the use of an air gun with claimant's arms in an overhead position. He also used an impact gun in an overhead position. Claimant testified he worked in the overhead position seven hours a day. When claimant began to notice problems with his shoulders and wrists, he reported it to Alberta Huerta, in Human Resources. Claimant also reported the problems to his supervisor, Reed. The pain started with the right shoulder and then went to the left. Claimant testified his shoulder would fall asleep in the morning and, during the day, turn to pain and would get worse. It was about a week after the right shoulder started hurting that the left shoulder began to hurt as well.

[2] ALJ Award at 5.

Claimant testified that the pain in the left shoulder feels like electric shocks. He feels this sensation every time he uses his arm.

After reporting his problems, claimant was sent for physical therapy. Despite therapy, claimant's problems failed to improve. Claimant was sent by the workers compensation insurance adjuster and his case manager to Bernard Hearon, M.D., for a consultation and treatment for his right shoulder pain on April 19, 2012. Dr. Hearon, who specializes in upper extremity surgery, diagnosed claimant with a right shoulder injury by repetitive overhead work, posttraumatic right shoulder pain, posttraumatic right subacromial impingement syndrome and a possible right rotator cuff tear. Diagnostic and therapeutic options were discussed with claimant through a translator and claimant was given a right shoulder subacromial injection. Claimant described the pain as a dull ache or sharp pain localized to the lateral deltoid and trapezius on the right side. Claimant reported his pain radiated to the wrist and was aggravated by shoulder abductions and certain positions with overhead work. Dr. Hearon noted claimant had painful forward flexion and abduction, positive impingement signs and trace weakness on resisted shoulder abduction. It was determined claimant's pain was the result of his repetitive work with an air pistol above shoulder height all day.

Dr. Hearon recommended formal physical therapy for shoulder range of motion, stretching and strengthening, as well as conservative modalities. Claimant was allowed to return to modified duty with no overhead work and no lifting more than 20 pounds on the right side. Claimant was instructed to return in four weeks if no better, and should consider an MRI.

Claimant met with Dr. Hearon again on May 17, 2012. At this visit, claimant complained of bilateral hand numbness and tingling, present for about two months. Claimant reported his symptoms were aggravated by his work activities and complained of nocturnal paresthesias every night and numbness every morning. He denied constant numbness. Claimant also complained of left shoulder pain after he started using his left upper extremity to compensate for his right shoulder pain. Dr. Hearon performed a nerve compression test, which was positive bilaterally and Phalen's test was also positive bilaterally. Static two-point discrimination was intact at 5 mm. There was no thenar atrophy on either side. Examination of the left shoulder revealed painful and somewhat limited forward flexion, but was otherwise unremarkable.

Dr. Hearon diagnosed bilateral carpal tunnel syndrome and compensatory left shoulder pain, both work-related. Diagnostic and therapeutic options were discussed with claimant through a translator and an EMG/NCT to confirm the bilateral carpal tunnel syndrome was recommended.

Dr. Hearon again examined claimant's right shoulder, which revealed good range of motion and positive Hawkins sign, but no rotator cuff weakness. The doctor scheduled

claimant for an MRI and returned claimant to modified duty with no lifting over 20 pounds on the right side. His diagnosis was post traumatic right shoulder impingement.

Claimant underwent an MRI of the right shoulder on May 22, 2012, which revealed tendinopathy of the rotator cuff tendon complex, a bursal sided-fibrillation/fraying of the supraspinatus tendon distally with no discrete partial-thickness defect or complete rotator cuff tendon tear, degenerative/stress-related change involving the acromioclavicular joint articulation, subdeltoid bursal inflammation/bursitis and fluid along the biceps tendon sheath which may represent tenosynovitis.

On May 25, 2012, claimant underwent an EMG/NCT. Claimant was found to have numbness in the bilateral hands, but a normal electrodiagnostic study of the bilateral upper extremities.

On May 31, 2012, claimant met with Dr. Hearon following the MRI and EMG/NCT. Claimant was diagnosed with right shoulder painful impingement and bilateral carpal tunnel syndrome clinically, left worse than right. The doctor opined that claimant's shoulder was the number one problem and administered another right subacromial injection. Claimant was instructed to return in four weeks and to continue with modified duty with no lifting over 20 pounds on the right side.

On June 28, 2012, claimant was seen again for follow-up. Claimant reported his May 31, 2012, injection provided two weeks of 50 percent relief in his right shoulder. He continued to be symptomatic and continued to complain of bilateral hand numbness and tingling associated with posterior neck pain and stiffness. He denied any previous neck injury while at work. Claimant's right shoulder displayed good range of motion, but he had mildly positive impingement signs and trace weakness on resisted shoulder abduction with pain. The cervical spine revealed good range of motion, but a positive cervical compression test for a left-sided radiculopathy down to the hand. A median nerve compression test was negative bilaterally. Dr. Hearon opined claimant should have a consultation with cervical spine specialist Dr. Brent Adams. Dr. Hearon noted claimant's bilateral upper extremity paresthesias and right shoulder pain may be due to cervical spine pathology, perhaps a degenerative cervical disc. He recommended the cervical spine be evaluated before any further treatment of the right shoulder. Claimant was instructed to continue with his restrictions.

On August 14, 2012, claimant met with Dr. Hearon for a check of his painful right shoulder impingement. Claimant had multiple complaints including neck pain, headaches and left shoulder pain. Through a translator, claimant had to be refocused on his right shoulder. Claimant was given another subacromial injection in the right shoulder and told to continue with his work restrictions. Dr. Hearon noted that after four weeks, should this course of treatment not help, surgery should be considered.

On September 11, 2012, claimant reported improvement for two and a half weeks following his latest injection, but then the pain returned to baseline. Because claimant showed no long lasting improvement, Dr. Hearon recommended diagnostic arthroscopy of the right shoulder, arthroscopic subacromial decompression, possible arthroscopic rotator cuff repair. Claimant was instructed to continue with his restrictions while he considered the recommended surgery.

On May 20, 2013, Dr. Hearon performed a right shoulder diagnostic arthroscopy, subacromial decompression, rotator cuff tear repair. It was determined that claimant's right shoulder injury was work-related.[3] Claimant had a good result from the surgery and eight days from surgery was returned to modified duty of no overhead work, no lifting more than 5 pounds on the right side and no use of power hand tools. He reported his pain was improved since the surgery. Claimant was reassured he was doing well and was instructed to continue with modified activity and physical therapy. This visit was conducted by physician assistant Lisa Frantz.

On June 18, 2013, at his four week post surgery visit, claimant reported his pain had improved, but he was having trouble moving his arm backward. Impingement signs were negative. Claimant was instructed to continue with his modified activity and physical therapy. This visit was again conducted by Ms. Frantz.

On July 16, 2013, eight weeks post surgery, claimant reported his right shoulder pain was improved. Claimant was assured by Ms. Frantz he was doing fine in his recovery and was returned to regular duty with no restrictions.

On August 13, 2013, claimant returned to Dr. Hearon's physician assistant for his twelve week post-surgery visit. Impingement and AC joint signs were negative and there was no rotator cuff weakness. Claimant was again reassured he was doing well and further treatment options were discussed. Dr. Hearon signed off on claimant's release to regular duty as tolerated with no restrictions and he told claimant to continue with the shoulder exercises on his own at home.

When claimant began treatment, he was authorized to do nothing more than perform oil changes for respondent. He would however, as a side job not associated with respondent, gather tires and wheels and resell them to either tire stores or his friends. These tires weighed around 15 pounds, which was within Dr. Hearon's original 20 pound lifting restriction.

Claimant never had any treatment for the left shoulder. He testified Dr. Hearon told him after the surgery on the right he was fine and he never saw the doctor again. Claimant was ultimately released without restrictions post surgery. He returned to work, but was not

[3] May 15, 2014 -- STIPULATION: KANSAS SURGERY AND RECOVERY CTR RECORDS.

allowed to work on the bonus line, which took away an opportunity for claimant to earn an additional $100 a week.

Respondent's insurance carrier had claimant put under video surveillance to determine/document claimant's activities and use of both hands/wrists and right shoulder. It was shown that claimant was working on cars during non-working hours. Claimant was observed over the course of two days. He was seen leaning and reaching in and around a vehicle. Claimant was also observed working on another vehicle in his garage. On another occasion, claimant was seen unloading tires and wheels from the back of a truck and a trailer.

Claimant was asked about the mechanical work he would perform on cars. He claimed to only work on his own cars, and denied working on any cars other than his own. He also denied buying wheels weighing more than 15 pounds, and could not explain the allegation that he worked on a Honda truck, as he does not own a Honda truck.

Claimant denied any prior workers compensation claims while working for any other employers. He did not recall filing prior workers compensation claims for repetitive injuries to his shoulders while working for meat processing plants in western Kansas.

Claimant's son, Bryan Pleitez, testified he has helped claimant pick up tires and wheels on several occasions from the salvage yard. He denies helping with any chrome wheels. He testified that the work claimant completed on the cars claimant owned included mostly oil changes and a few battery changes. Bryan testified the wheels, tires and occasional batteries they would purchase weighed less than the 20 pounds. However, on cross-examination, he admitted he never weighed those items and his weight estimates were just guesses.

Mike Casey, factory manager for respondent, supervised the production and maintenance operations in respondent's facility. Mr. Casey testified claimant spent two to three hours a day riveting and performing overhead work. This overhead work involved a mixture of picking up a pan, putting a sticker on it, shooting a few screws, shooting some inserts, taking them out of a tub and moving them down the line. Mr. Casey stated that claimant moved 300 to 400 units down the line a day. When claimant was assigned restrictions he was moved to another unit where he worked at a slower pace only moving 110 to 120 units a day. Mr. Casey confirmed this work did not exceed claimant's 20 pound restriction.

Claimant met with board certified orthopedic surgeon, Edward J. Prostic, M.D., at the court's request for an independent medical examination (IME) on December 17, 2013. Dr. Prostic noted symptoms of bilateral shoulder pain, right greater than the left, with pain going to the side of claimant's neck bilaterally, pain and popping and weakness in the shoulders. The examination of claimant's cervical spine was essentially normal, with no periscapular tenderness or spasm noted. No neurologic deficit was obvious in either arm.

Examination of the right shoulder revealed post-surgical scars, mild tightness and weakness with range of motion testing, but no instability. The left shoulder was tender, with tightness with range of motion testing. Tinel test was positive bilaterally for carpal tunnel syndrome.

A repeat EMG was recommended and if the results supported the carpal tunnel diagnosis, decompressive surgery should be offered. For the left shoulder, Dr. Prostic recommended strengthening only, no surgery. Dr. Prostic recommended a future medical treatment option be left open because claimant would likely require additional treatment to his arms and hands in the "not very distant future".[4] Claimant was rated at 15 percent to the right upper extremity at the shoulder, 8 percent of the left upper extremity at the shoulder and 10 percent to each upper extremity for the carpal tunnel syndrome, for an overall rating of 24 percent to the body as a whole on a functional basis. He determined the work-related trauma claimant sustained while working for respondent from January 3, 2012 through April 9, 2012, is the prevailing factor in the injury, medical condition, the need for medical treatment and the resulting disability or impairment.

Claimant testified he is doing different types of work every day and continues to work under restrictions. He continues to use an impact wrench, but only makes 200 units instead of 300 to 400. Claimant has pain in his shoulders and hands at the same level he had before surgery. Claimant testified he has not had surgery on his left shoulder because he wants to see if he can regain strength in his right shoulder first. He is delaying treatment for the left shoulder rather than refusing it. He also testified to being afraid of anesthesia because of his heart problems. The last time he was under anesthetic he came close to death, and doesn't want to take the risk because he must be able to work to provide for his family. Claimant has not seen much improvement from the right shoulder surgery. Claimant admits that some of the jobs he is performing continue to make his condition worse. Claimant has not tried any other types of treatment with any other doctors. He is aware that respondent is offering additional treatment and would consider it if he could be assured he will not have pain.

Alberta Huerta, HR specialist for respondent, testified she has worked for respondent for 11 years. Her duties entail anything that has to do with employee benefits, hiring, firing, write-ups, and workers compensation. Ms. Huerta testified that, with workers compensation claims, her job is to report the claims, track the claims, make sure the employees get to their appointments and schedule physical therapy until the claim is closed out. Ms. Huerta testified that employees are accommodated if needed.

Respondent has 245 employees, and has a safety specialist, Candace, who comes in every week for first and second shift to check on the employees and make sure everything is okay. If an employee complains about pain Candace will observe them

[4] Dr. Prostic's December 17, 2013, report at 3.

working to see what can be changed ergonomically. If the employee is doing something incorrectly she will correct them. Candace also helps new employees get through the phase of learning a new job. Candace also evaluates the tools that are used and makes recommendations about tools that need to be changed.

Ms. Huerta testified that she learned of claimant's shoulder issues at a weekly meeting with Candace. Candace keeps a log of observed and reported issues and what steps are taken towards a resolution. The issues are discussed at the meeting. Ms. Huerta testified that all options are exhausted in correcting a situation before an employee is sent to a doctor for treatment. When an employee needs to be sent for medical treatment a workers compensation claim is filed.

Ms. Huerta testified there are three production lines, with Lines 1 and 5 being the main ones. There are 32 people on Line 1 and about 25 on Line 5. Line 1 produces two types of units and Line 5 ten different types of units. All assembly positions are subject to bonuses, and everyone on the line gets the same bonus.

Candace evaluated claimant's work performance on January 19, 2012, and determined claimant needed to rotate the positions he was working on the line every two hours or 4 times a day to avoid more than two hours of the same movements. It was at the end of March or early April 2012 when it was determined claimant needed medical care. After claimant agreed, he was sent to Dr. Hearon for an orthopedic consultation. When Dr. Hearon assigned restrictions, claimant was moved from Line 1 to Line 5. Ms. Huerta testified claimant was not happy with this rotation and complained that the other employees were hassling him about the switch. There were days he actually had to leave work because the hassling was making him insecure. She testified claimant felt he was being punished and was not making as much money in this accommodated position. Claimant was reluctantly cooperative with the safety specialist. At times claimant didn't readily follow Candace's recommendations, needing to consult with his attorney first.

During the course of Candace's observations and visits with claimant, it came to light that claimant had employment outside of his job with respondent. There arose a concern that this employment might impact his ability to perform his work with respondent. Claimant's side job was doing mechanical repair work on vehicles. Ms. Huerta knew this because another employee, who happens to be a friend of claimant's, recommended she have him look at her vehicle.

Ms. Huerta testified after claimant had surgery he was not returned to his job on Line 1 because his position had been filled due to the fact he was on restrictions for a long period of time. It was insinuated that the person who filled claimant's position on Line 1 had less seniority than claimant. Ms. Huerta testified it was clear claimant preferred to work on Line 1 and were claimant cleared to do so, she saw no reason claimant couldn't, if there was an opening.

Since claimant's injury, respondent's policy has changed to allow rotation of all positions to avoid injury from prolonged repetitive activity. This created a learning curve for those in a new position, and could also cause someone additional physical problems. The goal is to get every employee rotated twice a day into two different jobs. All new employees take a post-offer screening test to place them in positions that fit their physical capabilities.

Ms. Huerta testified claimant is currently working on Line 5 with the opportunity to work 40 hours a week. His rate of pay is $11.71 an hour, with possible overtime. Ms. Huerta testified there were no plans to terminate claimant's employment as claimant is working in an acceptable and approved manner.

Claimant met with physical medicine and rehabilitation specialist Pedro Murati, M.D., for an evaluation on September 25, 2013, at the request of his attorney. Claimant's complaints were pain in both wrists and fingers on both hands, pain in the upper back, left shoulder pain, numbness in both hands in the mornings, neck pain that goes into the back of the head, headaches, right shoulder popping, and right shoulder pain after working.

Claimant reported working in assembly for nine years, with the job being mostly repetitive in nature. He reported his duties involved using air tools and pushing, pulling and moving units. He used a rivet gun and did a lot of overhead work. Claimant first noticed pain in both shoulders that gradually got worse until he had pain in both wrists and in the 2nd and 3rd digits on both hands. Claimant told the doctor the pain moved into his neck after progressing into his arms. He reported his shoulder pain to respondent in January 2012 and his complaints were allegedly ignored. When his pain progressed he reported it again and was sent to a doctor who sent him for therapy.

Dr. Murati examined claimant and found normal reflexes, decreased sensation bilaterally along the median distribution, weakness in the bilateral two-jaw chuck and 4 over 5 bilateral abductor pollicis brevis, consistent with carpal tunnel syndrome and a wrist ratio greater than 70 percent which predisposes carpal tunnel syndrome. Claimant's shoulder exam showed negative rotator cuff and Hawkins exam bilaterally. An O'Brien's exam was positive on the left and shoulder impingement on the right shoulder. X-rays of the right shoulder showed a distal clavicle excision. There was severe glenohumeral crepitus of the left shoulder. Range of motion in the right shoulder measured flexion of 145 and abduction of 145 with 60 degrees of internal rotation. The left shoulder, showing 140 degrees of flexion and 50 degrees of internal rotation, was otherwise full. Examination of the neck showed a negative Spurling's bilaterally. There was missing right lateral flexion and there were trigger points in both shoulder girdles extending into the cervical and thoracic paraspinals. The left occipitum was spastic and occipital sensation was intact.

Dr. Murati diagnosed status post diagnostic arthroscopy of the right shoulder, extensive intra-articular arthroscopic debridement including debridement of type III SLAP lesion, right shoulder arthroscopic subacromial decompression and treatment for

impingement syndrome, right shoulder arthroscopic distal clavicle excision as treatment for AC joint arthrosis, right shoulder suprascapular nerve block; bilateral carpal tunnel syndrome; left shoulder sprain with probable labral involvement; and myofascial pain syndrome of the bilateral shoulder girdles extending into the cervical and thoracic paraspinals. He opined that the diagnoses were within all reasonable medical probability a direct result from the work-related injury on January 3, 2012, during claimant's employment with respondent.

Dr. Murati did not issue any restrictions because claimant's attorney did not ask him to do so. He recommended at least yearly follow-ups on the neck, upper back, and bilateral upper extremities in case of any complications that may ensue. Dr. Murati also opined claimant needed treatment for the myofascial pain syndrome affecting the neck, upper back and both shoulder girdles. Dr. Murati testified that, had he been asked to issue restrictions, he would have instructed claimant, based on an eight hour day, to avoid repetitive hard grasping, perform only occasional grasping and frequent hand controls, avoid using knives, hooks, vibratory tools, and typewriting, no above the shoulder work, no reaching beyond 24 inches, lifting 35 pounds occasionally, 20 pounds frequently, 10 pounds constantly, no climbing ladders and no crawling.

Dr. Murati felt claimant was at maximum medical improvement and assigned the following permanent impairment based on the 4th edition of the AMA *Guides*: for the right carpal tunnel syndrome, 10 percent right upper extremity impairment; for loss of range of motion of the right shoulder, a 7 percent right upper extremity impairment. For the right shoulder status post subacromial decompression, a 10 percent right upper extremity impairment. For the right shoulder status post distal clavicle excision, a 10 percent right upper extremity impairment. These combines for a 32 percent right upper extremity impairment, which converts to a 19 percent whole person impairment. For the left carpal tunnel syndrome, a 10 percent left upper extremity impairment. For the severe glenohumeral creptius, an 18 percent left upper extremity impairment. These combine for a 26 percent left upper extremity impairment which converts to a 16 percent whole person impairment. For the myofascial pain syndrome affecting the cervical paraspinals, claimant was placed in Cervicothoracic DRE Category II for a 5 percent whole person impairment. For the myofascial pain syndrome affecting the thoracic paraspinals, claimant was placed in Thoracolumbar DRE Category II for a 5 percent whole person impairment. These whole person impairments combine for a 38 percent whole person functional impairment. Dr. Murati testified his rating would be 32 percent to the whole person if he deducted the cervical and upper back impairments.

In relation to prevailing factor Dr. Murati opined:

> The claimant sustained a multiple repetitive traumas at work which resulted in bilateral upper extremity, neck and upper back pain. He is a young person. His hobbies are not known as a direct cause for his current diagnoses. He is a non-smoker. He has no significant pre-existing injuries that would be related to his

> current diagnoses. Although there is speculation as to whether he may suffer from degenerative disc disease there is no objective evidence there is any and even then, the only way to determine that a disc is painful is through a discogram which to date has not been performed. The vast majority of people the claimant's age have degenerated cervical discs and it would be speculative to assign impairment to a condition which is age related. The examinee's neck condition is not disc in etiology but muscle and soft tissue. He has significant clinical findings that have given him diagnoses consistent with his described multiple repetitive traumas at work. Therefore, it is under all reasonable medical certainty and probability that the prevailing factor in the development of his conditions is the multiple repetitive traumas at work.[5]

Dr. Murati testified that someone with claimant's heart problems has a strong reason to have reservations about having surgery. He also testified that left shoulder surgery and carpal tunnel surgery could help claimant and lessen any restrictions, but there is also a chance surgery could fail and claimant could end up dead from complications related to his heart condition. However, the carpal tunnel surgery could be done with a block in the arm instead of under general anesthesia. Having surgery is not going to change claimant's impairment rating, it will only, with luck, make him able to do more.

On May 15, 2014, the parties stipulated into evidence the records from the New Medical Health Clinic. Claimant met with Neal Secrist, D.O., on March 5, 2008, reporting back pain, left shoulder pain and neck pain. Claimant reported difficulty sleeping and mild anxiety and depression from the passing of his mother on February 12, 2008. Claimant was started on an anti-inflammatory Naprosyn and told to follow-up on a prn basis.

The stipulated medical records indicate on September 30, 2008, claimant again met with Dr. Secrist, this time reporting low back pain, right shoulder pain and neck pain. Claimant reported the back pain would occasionally radiate down his legs and the neck and shoulder pain down his arm. Claimant reported getting frontal headaches from the neck pain. His pain level was a 5 to 6 out of 10. Claimant was again prescribed Naprosyn and started on Aristocort A ointment. Claimant returned on October 29, 2008, at which time claimant complained of the back pain radiating from the upper back to the front and upper right shoulder pain. Claimant had this pain daily and it was getting worse. The Naprosyn was continued and claimant instructed to return prn.

On October 6, 2009, claimant reported to Dr. Secrist, complaining of upper and mid back pain, bilateral shoulder pain and left ankle pain. Claimant reported this pain started three months prior, with no known injury. Follow-up was on a prn basis, with no indication in this record that claimant returned to Dr. Secrist.

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[5] Murati Depo., Ex. 1 at 5 (IME Report dated Sept. 25, 2014).

Claimant was seen by Wassim Shaheen, M.D., a cardiologist, on several occasions for heart issues. Dr. Shaheen confines his practice at Heartland Cardiology to issues with the heart. Claimant complained of chest pain and palpitations. This was after claimant had been admitted to Via Christi Hospital in 2010. Dr. Shaheen determined claimant had atrial fibrillation. Claimant was given medication to cure his arrhythmia.

Claimant met with Dr. Syed Raffi, on November 28, 2010, with new onset atrial fibrillation and chest pain. Claimant was admitted to the hospital with chest pain, fatigue, shortness of breath and weakness. Claimant also complained of bilateral tingling in the neck, bilateral shoulder pain, especially in the left, and back pain. Testing was completed and claimant was diagnosed with possible atrial fibrillation, chest pain, acute coronary syndrome and shortness of breath.

On February 14, 2012, claimant met with Dr. Shaheen for follow-up, and complained of intermittent chest pain since December 2011. The pain was on the left side and radiated to the left side of his back and into his left arm. The chest pain occurred with activity. Claimant was not sure if the chest pain was due to his muscle pain as he reported always having right shoulder pain. Claimant reported the pain was worse with activity. Claimant was given a stress test and had discomfort and pain despite a normal EKG and normal pictures of his heart. Claimant underwent a heart catheterization the next day to check for blockages. The test results were normal and when claimant was seen on February 22, 2012, he had no more chest discomfort and reported nothing about the shoulder pain. Claimant was released to regular activity.

Claimant was not seen again until the following year (February 2013) for follow-up and then seven months (October 2013) after that claimant called to report he was having heart palpitations and he was feeling tired. Claimant was put on a heart monitor, but there was no sign of atrial fibrillation. He was instructed to return in a year for follow-up.

Dr. Shaheen testified claimant's right shoulder discomfort would not cause atrial fibrillation, but could trigger it to recur. He testified atrial fibrillation does not prevent one from undergoing shoulder surgery or even carpal tunnel surgery. As for claimant's concern that anesthesia would affect his atrial fibrillation, Dr. Shaheen testified anesthesia or any type of stress may trigger atrial fibrillation, but the consequences are usually minor. When someone comes in and asks if it is safe to have surgery, he tells that person it is safe as long as the surgery is necessary. Dr. Shaheen testified that someone with a history of years of atrial fibrillation can develop congestive heart failure, start retaining fluids and develop shortness of breath.

Claimant met with board certified emergency medicine and preventative medicine specialist, John F. McMaster, M.D., for an evaluation on April 21, 2014, at respondent's request. Claimant had a limited ability to understand English as a second language, and was provided with an interpreter. Claimant denied any prior problems. Claimant reported working in meat packing plants in Southwest Kansas between 1992 and 2001.

Claimant reported injury to both shoulders, arms and hands as a result of constant use of both arms. Claimant received care from a number of providers. Claimant received physical therapy, injections and surgery to the right shoulder. At the time of this visit, claimant was working without physician imposed work restrictions or modifications.

Claimant reported right shoulder pain prior to a surgical intervention. He reported the shoulder pain was improved with surgery and replaced with a different painful condition involving the anterior aspect of the right shoulder. Claimant's greatest concern was bilateral shoulder pain involving both arms and hands. The left shoulder pain began after the right shoulder surgery. Claimant attributes his pain to the excessive use of his arms overhead, excessive lifting and repetitive tasks. Claimant uses Icy Hot ointment and Aleve to relieve his pain. The pain is present 50 to 75 percent of the time and is a 7 to 9 out of 10 on the pain scale. The pain affects claimant's ability to sleep.

Dr. McMaster noted claimant is being provided unrestricted, unmodified job activities on Line 5 on a full-time basis of 40 hours a week with the opportunity for overtime. Claimant also affirmed that over the last two years he and family members have been involved in activities involving the buying and selling of tires and wheels.

Dr. McMaster observed claimant to have a normal gait and he demonstrated the ability to ambulate without assistance, assume different positions, change positions, sit, stand, bend, squat and utilize his upper extremities without assistance or motion impairments. Claimant was found to be of average intelligence, was cooperative, forthcoming and judged to manifest medical concerns consistent with his cultural diversity.

Claimant reported global painful conditions involving both upper extremities and the upper back. Claimant reported his symptoms were aching and numbness. Claimant reported difficulty with several physical tasks, travel, sleep and job requirements.

Dr. McMaster diagnosed right shoulder impingement - status post arthroscopic debridement right shoulder, atrial fibrillation; nonspecific and non-differentiated upper extremity musculoskeletal complaints, non-occupational in origin. He did not believe claimant's right shoulder condition arose out of or was due to claimant's occupational tasks for respondent. He found claimant at maximum medical improvement and able to work with no restrictions.

Dr. McMaster was unable to causally relate the necessity of claimant's right shoulder surgical intervention to the occupational tasks as reported. He went on to opine the identified occupational tasks combined with the identified pathophysiology involving claimant's right shoulder, left shoulder, upper extremities, wrists and hands cannot be explained anatomically, physiologically or biomechanically as having resulted from claimant's required occupational duties. Based on the medical documentation, deposition testimony and video surveillance provided, along with a complete medical and scientific understanding of the disease processes reported, no occupationally induced alteration of

claimant's right shoulder or upper extremities was able to be verified. Dr. McMaster was unable to objectively verify claimant's diagnosed left shoulder pain and bilateral carpal tunnel syndrome.

Dr. McMaster opined, based upon a reasonable degree of medical certainty, combined with a medical and scientific understanding of injuries, illnesses and conditions involving the upper extremities, claimant's occupational tasks as reported to have occurred in early 2012 do not represent the prevailing factor giving rise to any identified medical condition involving either upper extremity.

Dr. McMaster allowed claimant no more than a 2 percent impairment to the right upper extremity pursuant to the AMA *Guides*, 4th edition after applying claimant's range of motion measurements. This impairment was as the result of the surgical intervention.

Dr. McMaster opined claimant's prognosis was excellent with respect to activities pursued both inside and outside the workplace. He was not able to anticipate a future need for medical treatment.

In summary, Dr. McMaster found from a medical and scientific standpoint, claimant did not sustain any significant permanent injury, illness or condition as a result of the required occupational tasks performed in the course of his employment with respondent. In terms of causation, he was unable to verify an occupational injury, illness or condition necessitating surgical intervention to the right shoulder.

Dr. McMaster diagnosed right shoulder impingement/upper extremity pain, non-occupational in origin as related to claimant's work-related injuries. He opined that claimant's subjective complaints presumed to be occupational in origin and ultimately resulting in a surgical intervention to his right shoulder, represented conditions commonly seen in the population at large. He did not assign any restrictions.

As for compensability, Dr. McMaster stated:

> Based on the findings identified in the course of this evaluation, this examinee necessitates no additional medical or surgical intervention to the right upper extremity at the present time. This body part had reached the point of maximum medical improvement.
>
> If the court were to find that the left shoulder and bilateral carpal tunnel symptoms were compensable, these body parts would not have reached the point of maximum medical benefit given his refusal for any additional therapeutic or surgical intervention. The suitability and medical advisability of this examinees refusal to forgo any additional treatment or surgical intervention to treat these body parts is unreasonable and not medically justified. Given his previous surgical history, medical risk factor analysis, combined with the

> objective findings identified in the course of this evaluation, the benefits of future therapeutic or surgical intervention exceed medically verifiable risks. [Footnote omitted][6]

Finally, Dr. McMaster found the prevailing factor giving rise to claimant's subjective complaints to be causally related to genetics, the aging process, normal activities of daily living and activities pursued outside his work environment, not the tasks required of claimant's job with RV Products.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2011 Supp. 44-501b(a)(b)(c) states:

> (a) It is the intent of the legislature that the workers compensation act shall be liberally construed only for the purpose of bringing employers and employees within the provisions of the act. The provisions of the workers compensation act shall be applied impartially to both employers and employees in cases arising thereunder.
> (b) If in any employment to which the workers compensation act applies, an employee suffers personal injury by accident, repetitive trauma or occupational disease arising out of and in the course of employment, the employer shall be liable to pay compensation to the employee in accordance with and subject to the provisions of the workers compensation act.
> (c) The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2011 Supp. 44-508(d)(e) states:

> (d) "Accident" means an undesigned, sudden and unexpected traumatic event , usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. "Accident" shall in no case be construed to include repetitive trauma in any form.
> (e) "Repetitive trauma" refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury. "Repetitive trauma" shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto.

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[6] McMaster Depo., Ex. 2 at 12 (April 21, 2014, IME Report).

In the case of injury by repetitive trauma, the date of injury shall be the earliest of:

(1) The date the employee, while employed for the employer against whom benefits are sought, is taken off work by a physician due to the diagnosed repetitive trauma;
(2) the date the employee, while employed for the employer against whom benefits are sought, is placed on modified or restricted duty by a physician due to the diagnosed repetitive trauma;
(3) the date the employee, while employed for the employer against whom benefits are sought, is advised by a physician that the condition is work-related; or
(4) the last day worked, if the employee no longer works for the employer against whom benefits are sought.

In no case shall the date of accident be later than the last date worked.

K.S.A. 2011 Supp. 44-508(f)(1)(2)(A)(3)(A) states:

(f) (1) "Personal injury" and "injury" mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.
(2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.
(A) An injury by repetitive trauma shall be deemed to arise out of employment only if:
(i) The employment exposed the worker to an increased risk or hazard which the worker would not have been exposed in normal non-employment life;
(ii) the increased risk or hazard to which the employment exposed the worker is the prevailing factor in causing the repetitive trauma; and
(iii) the repetitive trauma is the prevailing factor in causing both the medical condition and resulting disability or impairment.
. . .
(3) (A) The words "arising out of and in the course of employment" as used in the workers compensation act shall not be construed to include:
(i) Injury which occurred as a result of the natural aging process or by the normal activities of day-to-day living;
(ii) accident or injury which arose out of a neutral risk with no particular employment or personal character;
(iii) accident or injury which arose out of a risk personal to the worker; or
(iv) accident or injury which arose either directly or indirectly from idiopathic causes.

K.S.A. 2011 Supp. 44-508(g) states:

(g) "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor" in a given

> case, the administrative law judge shall consider all relevant evidence submitted by the parties.

The ALJ accurately noted the diametric opinions of Dr. McMaster and Dr. Murati, rejecting both as non-persuasive. The Board agrees the opinions are so radically opposite they cannot be seen as credible in this matter.

Dr. Prostic, the court appointed independent medical examiner, provides a more balanced opinion regarding claimant's problems and how they relate to claimant's work for respondent. In reaching his opinion, Dr. Prostic utilized the medical reports of claimant's treating physician, Dr. Hearon. Claimant was found to have suffered a Type III SLAP lesion, subacromial impingement and acromioclavicular arthritis. Surgery involving biceps debridement, subacromial decompression and excision of the lateral clavicle as well as a suprascapular nerve block were the result of work injuries suffered as claimant performed his duties for respondent. Claimant was diagnosed with bilateral carpal tunnel syndrome, also resulting from the physical labors of his job with respondent. The Board finds the opinions of Dr. Prostic convincing in that claimant suffered injury by repetitive trauma which arose out of and in the course of his employment with respondent. Claimant's job duties were the prevailing factor leading to the medical conditions and resulting impairment suffered by claimant in this matter.

K.A.R. 51-9-5 states:

> An unreasonable refusal of the employee to submit to medical or surgical treatment, when the danger to life would be small and the probabilities of a permanent cure great, may result in denial or termination of compensation beyond the period of time that the injured worker would have been disabled had the worker submitted to medical or surgical treatment, but only after a hearing as to the reasonableness of such refusal.

Respondent contends claimant should be denied compensation in this matter due to claimant's reluctance to submit to additional medical treatment to his left shoulder and bilateral carpal tunnel syndrome. However, no health care provider in this matter has stated the offered treatment would create the probability of a permanent cure. Claimant has expressed reluctance to undergo added surgery due to his earlier heart related difficulties. Additionally, claimant expressed concern that the earlier right shoulder surgery did not cure him of the work-related injuries. Either concern raises legitimate questions regarding future surgery. The Board does not find claimant in violation of the policies set forth in K.A.R. 51-9-5. Respondent's request for a denial of benefits due to claimant's refusal to submit to additional medical treatment is denied as claimant's refusal is not found to be unreasonable under these circumstances.

K.S.A. 2011 Supp. 44-508(u) states:

> (u) "Functional impairment" means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of impairment, if the impairment is contained therein.

In finding the opinions expressed by Dr. Prostic as the most credible, the ALJ adopted the functional impairment opinions expressed therein. The Board finds the Award of the ALJ, based upon Dr. Prostic's opinions, to be the most accurate and credible in this matter. Claimant has suffered a whole person functional impairment of 24 percent as the result of his work-related injuries with respondent. The Award of the ALJ is affirmed by the Board.

Dr. Prostic's concerns regarding claimant's potential need for future medical treatment to his shoulders and hands are legitimate. The Board affirms the portion of the Award which allows future medical treatment upon proper application to the Director.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed. Claimant suffered permanent partial disability on a functional basis for a 24 percent whole person impairment, from injuries suffered through repetitive trauma, which arose out of and in the course of his employment with respondent. Claimant did not unreasonably refuse additional medical treatment and respondent's request that claimant's benefits be terminated is denied. The award of future medical treatment upon application to the Director is affirmed.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge John D. Clark dated June 18, 2014, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of November, 2014.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

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Gary K. Jones, Administrative Law Judge